Health by Numbers

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Hospital Community Benefits in 2003

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The organization of Rhode Island's thirteen community hospitals[1] as 501(c)(3) corporations enables them to carry out their charitable missions without the tax liabilities imposed on for-profit companies. The value of this "not-for-profit" designation is considerable and has four-fold primary significance:

1. *Exemption from local property taxes,*[2]
2. *Exemption from state and federal corporate taxes,*
3. *Preferential borrowing at tax-exempt rates,*[3] *and*
4. *The ability to solicit charitable donations and to invest those monies without tax liability on income earned.*

The community, in waiving its right to these revenues, implicitly anticipates that it will benefit from the "public good" of certain hospital benefits, including the provision of healthcare services to all regardless of ability to pay (i.e., uncompensated care).

Rhode Island was one of the first states in the nation to examine hospital community benefits. Since 1989, the Rhode Island Department of Health (HEALTH) has analyzed and reported on this issue.[4] In 1997, the General Assembly passed the Hospital Conversions Act (the Act) that further codified the public reporting of these activities.

Methods. The Act and its regulations broadly define community benefits as:

> *"…the provision of hospital services that meet the ongoing needs of the community for primary and emergency care …and shall …not be limited to, charity care and uncompensated care. (and)…programs …that meet the needs of the medically indigent; linkages with community partners(,) …non-revenue producing services(,) …public advocacy …(and) scientific, medical research, or educational activities."*

In order to quantify the hospitals' efforts in providing community benefits, an annual survey instrument is used to collect descriptive data, and audited financial statements and Medicare Cost Reports are used to provide financial data.

In addition, HEALTH's Minority Health Advisory Committee has advocated that the hospitals' diversity of governance and administration is an important part of their corporate mission. The Committee reasoned that the health of a community is enhanced when it sees itself actively participating in its own healthcare. Therefore, data have also been collected on hospital diversity and benchmarked to the general population in the state.

Results. Notwithstanding the fairly broad regulatory definition of community benefits, charity care and bad debt remain the most fundamental measures of a hospital's community benefits. Both represent an accounting for the uncompensated healthcare provided by a hospital, even though they are technically different from an accounting standpoint and practically different from the patient's standpoint. Uncompensated care as a whole simply means that payment was not received or was waived by the hospital, it does not mean that reimbursement was insufficient to cover expenses. Charity care is the charges recorded for services delivered but never billed because the hospital makes a prospective determination the patient is incapable of payment. Bad debt, on the other hand, is the billing for services rendered but never collected and written off as a business expense.

Figure 1 provides the statewide charity care and bad debt amounts from 1995 through 2003. Over this nine-year period, the uncompensated care amounts were fairly consistent, averaging $53.8 million annually. "Fitting" a trend line to these historical data shows uncompensated care increasing by almost $1.3 million per year, on average.

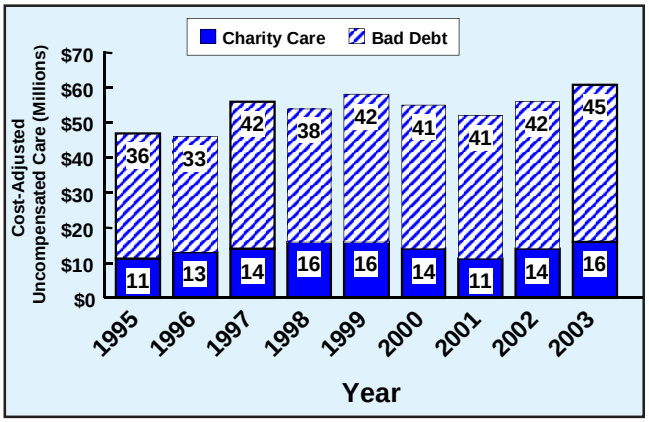

Figure 1. *Uncompensated Hospital Care, by Year and Type, Rhode Island, 1995-2003.*

The operational classification of charity care and bad debt has been blurred by non-uniform accounting practices and determinations at the time of admission. Often there is reticence on the part of individuals to disclose financial hardship, and so, the eventual non-payment for services falls under bad debt rather than charity care. It is for this reason, the somewhat arbitrary categorization of non-paying patients, that combining both charity care and bad debt is the most precise way to measure a hospital's 'burden' in treating the indigent.

Figure 2 presents each hospital's charity care and bad debt amounts together, on a relative basis for the period 2000-2003. Aggregating four years of data removes any outliers associated with a single year's reporting. Presenting the value as a percentage of the

hospital's net patient revenue further standardizes the statistic for comparison purposes. Uncompensated care percentages ranged from highs greater than 4% at Butler, Newport, Roger Williams and Rhode Island Hospitals to lows below 2% at Rehabilitation Hospital and Women & Infants Hospital.

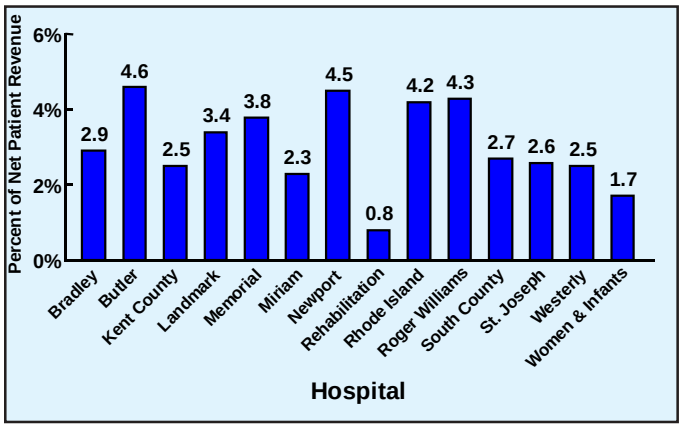

Figure 2. *Uncompensated Hospital Care as Percent of Net Patient Revenue, by Hospital, Rhode Island, 2000-2003 (Combined).*

Table 1 presents the level of hospital diversity statewide. Hospital governance (i.e., Board members and senior administrators) is not diverse, not reflective of the general population, nor has it changed appreciably since 1998. In 1998, hospital Boards were 27% female, 5% racial minority, and 0% Hispanic. In 2003, that representation was 27% female, 6% racial minority, and 1% Hispanic. The only category that mirrors the general population was the Black representation at 4.5%.

With the exception of gender diversity, senior hospital administrators were even less diverse than the Boards. In 1998, hospital administrators were 35% female, 0% racial minority, and 0% Hispanic compared with 43% female, 2% racial minority, and 0% Hispanic in 2003. Asians were the only minorities represented at all, and Hispanics and Blacks were totally absent.

Discussion. Since 1998, HEALTH has had formal data collection efforts to track and quantify hospital community benefits. As the debate over what constitutes a 'charitable' organization continues, policy makers struggle with the need for more and better information. In response, HEALTH has expanded its public reporting and revised the metrics used to frame and analyze the issues.

Table 1. Demographic Diversity of Hospital Board Members and Senior Administrative Staff, Rhode Island, 2003

DEMOGRAPHIC CHARACTERISTICS		HOSPITAL BOARD MEMBERS (N=287)	HOSPITAL ADMINISTRATIVE STAFF[1] (N=114)	RHODE ISLAND POPULATION[2]
Ethnicity	Hispanic/Latino	*1%*	*0%*	*9%*
	Not Hispanic/Latino	*99%*	*100%*	*91%*
	Totals	*100%*	*100%*	*100%*
Race	American Indian	*0%*	*0%*	*0.5%*
	Asian	*1.4%*	*1.8%*	*2.3%*
	Black/African-American	*4.5%*	*0%*	*4.5%*
	Native Hawaiian/Islander	*0.3%*	*0%*	*0.1%*
	White	*93.7%*	*98.2%*	*84.9%*
	Other or Multiple Races	*0%*	*0%*	*7.7%*
	Totals	*100%*	*100%*	*100%*
Gender	Female	*27%*	*43%*	*52%*
	Male	*73%*	*57%*	*48%*
	Totals	*100%*	*100%*	*100%*

[1]Vice-President level (however titled) and above
[2]2000 U.S. Census data

In addition, HEALTH also uses this opportunity to align the hospitals' community benefits activities with its own goals of Healthy Rhode Islanders 2010, the blueprint for public health in the state. Understandably, not every hospital addresses all of the state's 2010 objectives, because each hospital's priorities should reflect its own community needs, but it does serve to illustrate where the industry and the state may work together effectively.

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References

1 Rehabilitation Hospital of RI, a Limited Partnership, became a wholly owned subsidiary of Landmark in June 2000.
2 Some hospitals offer payment in lieu of taxes to their host communities.
3 Tax-exempt interest rates are typically less than rates charged to commercial borrowers.
4 Cryan B, *Uncompensated Care Services in RI's Community Hospitals.* Providence RI: Rhode Island Department of Health. 1989; and Cryan B. *Uncompensated Care and Tax Exemption of RI's Hospitals.* Providence RI: Rhode Island Department of Health. 1993.

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